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8	BEFORE THE BOARD OF REGISTERED NURSING
	DEPARTMENT OF CONSUMER AFFAIRS
9	STATE OF CALIFORNIA
10	In the Matter of the Accusation Against: Case No. 2011- 743
11	In the Matter of the Accusation Against: Case No.
	KRISTIANA JANE YOUNG ACCUSATION
12	914 Ruth Court Pacific Grove, CA 93950
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14	818 Sunset Drive, #11 Pacific Grove, CA 93950
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·	Registered Nurse License No. 708819
16	Respondent.
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18	Complainant alleges:
19	PARTIES
20	1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
21	official capacity as the Executive Officer of the Board of Registered Nursing, Department of
22	Consumer Affairs.
23	2. On or about July 27, 2007, the Board of Registered Nursing issued Registered Nurse
24	License Number 708819 to Kristiana Jane Young (Respondent). The Registered Nurse License
25	expired on May 31, 2009, and has not been renewed.
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Accusation

3. This Accusation is brought before the Board of Registered Nursing (Board),
Department of Consumer Affairs, under the authority of the following laws. All section
references are to the Business and Professions Code unless otherwise indicated.

- 4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
 - 5. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct,

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6. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

- "(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
- "(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

- i. On August 13, 2008 at 10:16, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document

 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- j. On August 13, 2008 at 12:27, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document
 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- k. On August 16, 2008 at 16:07, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document

 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- 1. On August 17, 2008 at 07:55, Respondent removed 4 mg of
 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document
 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- m. On August 17, 2008 at 09:08, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document
 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- n. On August 17, 2008 at 10:38, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document

 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- o. On August 17, 2008 at 12:53, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document
 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- p. On August 17, 2008 at 17:15, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document

 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- q. On August 17, 2008 at 19:43, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document

 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.

- r. On August 18, 2008 at 18:41, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document

 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- s. On August 19, 2008, the physician for Patient 2 ordered 2 mg Hydromorphone/Dilaudid IV every three to four hours as needed for pain.
- t. On August 20, 2008 at 09:52, Respondent removed 2 mg of
 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document
 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- u. On August 21, 2008 at 07:39, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document
 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- v. On August 21, 2008 at 11:52, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document
 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- w. On August 21, 2008 at 14:23, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document
 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- x. On August 25, 2008 at 17:59, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document
 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- y. On August 25, 2008 at 12:07, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document

 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.
- z. On August 25, 2008 at 16:06, Respondent removed 4 mg of

 Hydromorphone/Dilaudid from the hospital AcuDose. Respondent failed to document

 administration or wastage of the Hydromorphone/Dilaudid, or account for its disposition.

PRAYER WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, 2 and that following the hearing, the Board of Registered Nursing issue a decision: 3 Revoking or suspending Registered Nurse License Number 708819, issued to 4 Kristiana Jane Young; Ordering Kristiana Jane Young to pay the Board of Registered Nursing the reasonable 6 costs of the investigation and enforcement of this case, pursuant to Business and Professions 7 Code section 125.3; 8 Taking such other and further action as deemed necessary and proper. 9 3. 10 11 12 13 **Executive Officer** 14 Board of Registered Nursing Department of Consumer Affairs 15 State of California Complainant 16 17 SF2011200271 20413001.doc 18 19 20 21 22 23 24 25 26 27 28